MEDICAL BOARD OF CALIFORNIA
FINAL STATEMENT OF REASONS

Hearing Date: November 7, 2003

(1) Section(s) Affected: 1355.31

Updated Information

The Initial Statement of Reasons is included in the file. The information contained therein is updated as follows:

Local Mandate

A mandate is not imposed on local agencies or school districts.

Small Business Impact

This action has no significant adverse economic impact on small businesses.

Consideration of Alternatives

No reasonable alternative which was considered or that has otherwise been identified and brought to the attention of the board/bureau/commission/program would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Objections or Recommendations/Responses

_____ There were no objections or recommendations regarding the proposed action.

__x___ The following recommendation and/or objections were made regarding the proposed action:

(1) California Association of Professional Liability Insurers (CAPLI) objected to the proposed regulation because it was their opinion that the methodology used to determine risk classification and "average" is questionable.

a) High Risk Classification: They object to the methodology to determine high risk classification based on only frequency of lawsuit settlement, as the number of physicians settling multiple lawsuits is from a small sample and during the a 10 year period is "bound to be low."

b) Average Settlement: They questioned the use of a "mean" average rather than a "median" average, as a mean is affected by a few extremely large or extremely small values outside of the rest of the data.

Rejected:

a) High Risk Classification should be assed on lawsuit frequency, as the law relates to specialty risk is clearly for the purpose of classifying specialties that are at high risk of multiple lawsuit settlements. The law provides that those specialties at high risk will have public disclosure only when they've settled four suits, rather than three for the low risk specialties. Clearly, the law relating to specialty risk is specifically for those at risk of multiple lawsuit settlements.

b) Average Settlement . The use of the mean average is more likely to result in a more representative average for the public disclosure of settlements. As the CAPLI quoted the National Council of Teachers of Mathematics in their objection letter, "The mean and median each have advantages and disadvantages when used to describe data sets." Neither methodology is without faults.

(1) California Association of Professional Liability Insurers agreed with the CMA recommendation that the Medical Board adopt interim regulations categorizing all specialties at high risk, "while we explore more sophisticated and fair ways to approach the problem at hand."

Rejected:

See below response to CMA's objection. (3) c)

(2) California Medical Association (CMA) objected to the proposed regulations as follows:

a) They assert that the Medical Board does not have the authority to design the proposed system solely on "inaccurate data" concerning either the number of license physicians in various specialties or the particular specialty of physicians who have settled cases over the last five years. AB 1586 requires that specialty data be collected from all physicians regarding their specialty, which will be an accurate number of physicians practicing a specialty in California. This data has only started to be collected, and will not be available until 2005.

Rejected:

The law grants the authority to the Board to develop specialty risk categories based on data from the malpractice insurance carriers. In preparation to promulgate these regulations, the Medical Board repeatedly asked the malpractice insurers for their data to determine the risk of specialties and, to date, has never received any data specifically for this purpose. For that reason, the Board used the mandatory reports filed by the malpractice insures (under Business & Professions Codes 800, et sec.) over the past 10 years to determine the number of physicians sued in each specialty. As for the numbers of physicians determined to be in each specialty, those figures were not developed without data, as the American Board of Medical Specialties publishes an annual report on board certified specialists in each state, including California, which was utilized. As almost 80% of all physicians are board-certified, and the Board has the number of licensed physicians in the state each year, this method of calculation is sound. In addition the Board utilized, the American Medical Association's directory of physician profiles, which lists specialty. While it is true that assumptions were made, they were assumptions based on reasonable data. It is also true that there will be data collected as a result of AB 1586, however, it is likely that it too will be flawed, as it will be based on the self-reporting of physicians, and will not be verified by any agency. There is simply no system that will be entirely accurate at any given moment, even the AB 1586 reporting system, as physicians retire, move outside of the state, change specialty, move to non-clinical and administrative positions, and so forth, during any given year. Note: the CMA states that the data used was gathered for a five-year period. That is incorrect. The Board used data from 10 years of malpractice settlement reports from malpractice carriers.

b) California Medical Association objects to the Board's methodology in determining the specialty of those who settled malpractice cases in the past, stating that it based the statistical results on "a guess as to the specialty of the physician because that information is not required in the settlement reports." They state that they would "urge that the Board use the carrier classifications as the basis for determining "high" or "low" risk for specialty.

Rejected:
The determination of specialty for the malpractice settlement was based on far more than a "guess" --- they were based on information included in the malpractice reports, the AMA physician

directory, investigations, and specialty board certification. While the reports did not specifically include a question relating to specialty practice, the procedure or diagnosis on which the case was based could be determined from the forms and investigative data. (Case settled for "brain damage resulting from vaginal birth," "death of patient from uncontrolled bleeding following hysterectomy," etc., would be reasonably considered OB/GYN cases) The use of carrier high risk specialty classifications is not an option, as they provided no data, simply a list of specialties provided by the CMA accompanied by no data. In addition, the carriers have explained that they classify high risk for different purposes than for risk of multiple settlements. The amount of payout (the risk of expensive settlements or judgments and legal costs), location of practice, clientele served --- all of these factors are actuarial in nature to determine the carrier's risk of payout, not just for risk of multiple settlements.

c) California Medical Association objects to the proposed regulation and would recommend that the Board adopt interim regulations that would classify all specialties at "high risk" until there is more accurate data available.

Rejected:
The Medical Board has repeatedly requested data from the malpractice carriers for the purpose of promulgating the regulations. To date, no data from any carrier has been received. It is important to note that the malpractice carriers strongly objected to the legislation that gave rise to these regulations. The data used by the Board in determining specialty risk was based on the legally mandated malpractice settlement reports from the malpractice carriers to the Board's enforcement program during a 10 year period. Therefore, the information used was based on data from the malpractice carriers, although not specifically provided for this regulatory purpose. If the statistical data used by the Board is in any way incorrect, the malpractice carriers have been given ample time to provide contrary data. To date, no contrary data has been received.

(4) The American College of Obstetricians and Gynecologists (ACOG) objected to the proposed regulation, questioning the methodology and statistical information that placed OB/GYN physicians at "low risk." They provided figures placing the risk ratio at 1:68 rather than 1:124.

Accepted; language modified to place "obstetrics" at high risk for multiple settlements

As stated above, the methodology used to determine specialty practice is based on ABMS and AMA reports on specialty practice, as well as malpractice reports as they relate to specific settlements. The ACOG statistics are based only on their membership, which is comprised of only board-certified Obstetrician/Gynecologists who voluntarily join their organization. There are a number of physicians practicing OB/GYN who are not certified and not qualified to be members of the College, as well as certified OB/GYNs who are not a members. That said, however, the Board's method of determining risk was based on grouping Obstetrics and Gynecology into one practice specialty. That is not entirely satisfactory, as there are a number of Gynecologists who do not practice Obstetrics, and Obstetrics is generally accepted as being at higher risk for lawsuit. For that reason, the Board modified its originally proposed regulatory language to grant Obstetrics as a separate specialty, placing it in the "high-risk" category. Solely Gynecological practice will remain in low risk.

___x__ There were no comments received objecting to or supporting the modified proposal.